Chapter 11

Multicultural Issues

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Introduction

Cultural considerations are receiving increasing attention in the field of mental health, as our pluralistic society demands that providers of mental health services be culturally sensitive as well as competent. Therapists working with traumatized children and families must be especially attuned to cultural issues. Cultural definitions of "family" and what constitute appropriate family dynamics and roles can vary widely. Furthermore, there may be a great deal of within-group cultural variation even within a single family system, and intergenerational issues that may need to be recognized and sensitively addressed by the therapist (Gushue and Sciarra, 1995). Gushue and Sciarra state that "the family and multicultural perspectives in counseling and psychotherapy share the premise that no adequate understanding of a particular individual may be attained apart from an understanding of a larger context — family or culture, respectively — that shapes that person…" (p. 586). Thus, therapists who regularly work with children and families are in a good position to — and indeed must — evaluate and address cultural issues in counseling. Furthermore, child welfare codes in most states mandate that child protective systems incorporate cultural information when interventions are made with families to protect children. For example, California Welfare & Institutional Code, 1996, section 16509 states that "cultural and religious childrearing practices and beliefs which differ from general community standards shall not in themselves create a need for child welfare services unless the practices present a specific danger to the physical or emotional safety of the child" (p. 150). On a national level, the federal Indian Child Welfare Act (ICWA) dictates that tribal authorities must be involved in decisions to remove an Indian child from a home, and that an Indian child must be placed in an Indian home whenever possible. For a detailed discussion of cultural and legal issues, see Levesque (2000).

This chapter is intended to provide an overview of fundamental multicultural counseling issues and how they pertain to working with families and child trauma victims. The discussion is limited to issues that transcend specific cultural groups. For a detailed discussion of universal or transcultural approaches to multicultural counseling, see Fukuyama (1990). In addition to competence in dealing with consumers of mental health, it is also imperative for providers of mental health services to attend to their own cultural contexts. The first sections deal with therapist self-awareness and client within-group variability (acculturation and racial identity). The chapter concludes with issues pertaining to assessment, intervention and ethics. It should be noted that culture-specific knowledge — while not the focus here — is important and necessary. In counseling situations in which the mental health professional is unfamiliar with the client's (or family's) cultural background, we recommend professional development in the form of reading, inservice training, and consultation with other mental health professionals and indigenous healers. For detailed discussions on referral to and consultation with traditional healers, see Lee and Armstrong (1995) and Atkinson, Thompson and Grant (1993).

Therapist Self-Awareness

When working in a multicultural context, it is imperative to be aware of one's own frame of reference and worldview. The term "worldview" is defined by Lonner and Ibrahim (1996) as "how an individual sees the world from a moral, social, ethical, and philosophical perspective. It is the source of a person's values, beliefs, and assumptions" (p. 295). Embedded in this definition is the fact that the helping professions have their own unique biases and ways of viewing the world and other people. Furthermore, most professional training in counseling and psychotherapy is extremely culture-bound, in that many of the assumptions that underlie our training are distinctly Western (Fukuyama, 1990; Pedersen, 1987). The values that therapists

bring to the counseling setting may be incongruent with those of many of the clients and families that they serve. Pedersen (1987) has discussed some of the cultural biases of counseling: an assumption of the universality of "normality"; an emphasis on individualism and independence; an expectation of openness and "psychological mindedness"; and an expectation of client self-disclosure. Awareness of one's own worldview and specific biases becomes particularly important during the assessment phase of working with child trauma victims and their families, since behavior that is seen as deviant or abnormal may in fact be culturally appropriate. The therapist must be attuned to the danger of re-traumatizing clients and families by inappropriately pathologizing them. For example, avoiding eye contact, lowering the head and disclosing very little may be a sign of respect in some cultures, but a Western-trained therapist might interpret this as depression, avoidance or resistance.

Within-Group Differences

The subject of within-group variability has received much attention from mental health professionals. Within-group variability results from the existence of subgroups within a larger population. For example, the Hispanic-American population consists of individuals of Mexican, Puerto Rican, and Cuban descent, among others. Similarly, the Asian-American population consists of people from many different and distinct groups. Clearly, there is a great deal of variation within the major cultural groups. However, tremendous variation also exists within each subgroup. Sevig, Highlen, and Adams (2000) recently noted the importance of avoiding stereotyping by attending to within-group differences. For example, while some Asian individuals may tend to avoid direct eye contact out of deference and respect, others may not. In this section, acculturation and racial identity are considered as they relate to families and child trauma victims.

Acculturation

The term "acculturation" has been used to refer to the process of adaptation that a population experiences as it comes into contact with another culture. Ethnic families and individuals in the U.S. vary greatly with regard to acculturation level, depending on factors such as geographic location, socioeconomic status and overall exposure to U.S. mainstream culture. For a thorough discussion of acculturation, see Casas & Vasquez (1996). Culturally aware therapists are informed of immigration and related acculturation issues for individual clients as well as families. For example, the needs of a client who left Mexico for economic reasons and is well acculturated differ greatly from those of a family that fled violence in Guatemala or Honduras and has had little contact with the dominant culture.

Acculturation level can vary significantly between generations and within a single family. For example, parents may maintain close ties to their roots while their children are exposed to the mainstream culture through school attendance and general exposure to outside influences (Gushue and Sciarra, 1995). Therapists working with these families need to be skilled at recognizing and negotiating such intrafamilial differences, since there may exist significant frustration and lack of understanding between generations. When working with a family, therapists may find themselves having difficulty connecting with less acculturated parents. Atkinson et al. (1993) suggested that level of acculturation should, at least in part, dictate what role therapists take with clients and what types of interventions they employ. For example, the roles of adviser, advocate, consultant or facilitator of indigenous support and healing systems may be appropriate and helpful to clients and families with limited exposure to the mainstream culture. However, these approaches may be ineffective or even offensive to a more acculturated family.

Two additional points regarding acculturation are worth noting. First, level of acculturation can play a role in an individual's or family's decision to enter or leave therapy, and in the level of trust placed in the helping professional. Less acculturated clients may be less familiar with — and more distrustful of — professional mental health services. It is important for the helping professional to recognize the validity of this distrust, as there is consensus that our mental health system has generally failed to provide culturally responsive treatment (for example, lack of bilingual therapists and access to low-cost treatment; see Leong, Wagner, & Tata, 1995; Levesque, 2000). The culturally responsive therapist recognizes that an initial — and possibly

extended — period of trust building may be necessary before any significant therapeutic work can take place. Second, old "assimilation" models of acculturation, which assumed that movement toward or identification with one culture necessitated movement away from the other, have given way to recognition of the reality that many individuals are bicultural and able to independently identify with more than one culture (Casas & Pytluk, 1995). When working with children and families, it is important to note that family members often adopt different roles outside of the home than inside (for example, speaking English at school or work and identifying more with Anglo culture, while speaking one's native language and being more "traditional" at home). It is important to accurately assess variations in behavior and not automatically pathologize or label them as erratic.

Racial Identity Status

Another marker of within-group variability is racial identity status, which is based on the premise that people of color are at various stages of dealing with internalized racism. Identity development models generally assume that individuals range from non-awareness or non-identification with one's racial or ethnic group (identification with the dominant culture) to full awareness and appreciation of self as well as others (Helms, 1995; Parham, 1989). The middle stages consist of the accumulation of information, increasing awareness of one's oppressed status, and the denigration of the dominant culture. As with acculturation, members of the same culture or family can vary greatly in terms of their identity status. Gushue and Sciarra (1995) suggest that the creation of a "cultural map," in which the racial identity status of each family member (as well as the therapist) is noted, can assist in determining the types of interventions to employ with a family. These authors emphasize the importance of attending to racial identity issues, as they bear directly on individuals' valuing of self and heritage.

Automatic assignment to a therapist of the same race or ethnicity with no attention to the racial identity status of the therapist or the client can result in premature termination or poor outcome. Depending on racial identity status, a client may prefer to work with a therapist from the same background, while another may want a therapist from the mainstream culture. In one agency, a Mexican-American client was automatically assigned to a Mexican-American therapist, while no attention was given to her level of racial identity. Consequently, she dropped out of therapy three times. When assigned to a culturally sensitive Anglo therapist, she was able to work on issues related to years of physical and emotional abuse as a child. If therapists are not aware of their own level of racial identity, they may project their own worldview onto the client and consequently be ineffective or damaging. For example, a therapist in a child abuse agency who rejected the dominant culture and associated only with her own cultural group did not work effectively with a parent from the same culture who identified with the dominant culture. When assigned to a culturally sensitive therapist from the mainstream culture, the client was able to resolve her parenting issues.

Assessment, Intervention and Ethical Issues

Consideration of within-group differences (acculturation and racial identity status) is an important component of the assessment process, in that one's relationship to a culture directly affects the way in which problems and symptoms are perceived and reported (Suzuki & Kugler, 1995). For example, a parent in an earlier stage of racial identity development might tend to minimize the degree to which his or her child is subjected to racism at school. The family therapist who is able to accurately assess this dynamic may be able to work with the parent in a more effective and compassionate way. There are clearly significant differences between cultural groups as well and — as discussed above — it is important to have at least some knowledge of the group with which one is working. For this reason, the task force recommends professional development and consultation with appropriate professionals and culturally prescribed healers. Furthermore, an ethical duty to refer emerges if a therapist lacks the knowledge or ability to appropriately assess and treat an individual or family.

Culturally sensitive mental health professionals are aware that they bring their own biases and set of values (both personal and professional) into the counseling arena. Kleinman (1988) mentions the "category fallacy"

of projecting one culture's diagnostic categories onto individuals of another culture without ensuring that those categories have validity in that culture. Trimble et al. (1996) discussed an example where a lack of cultural awareness on the part of mental health professionals has often resulted in inappropriate diagnostic practices. They describe a "cultural time-out" in which certain Sioux Indians regularly participate, where symptoms similar to depression are typically manifested. This behavior is culturally appropriate and even expected, but therapists outside that culture may see it as a problem due to the projection of their own diagnostic classification system.

The category fallacy issue also applies to standardized psychological and intellectual testing. Clinicians must be cautious when utilizing formalized assessment instruments, as many of these instruments were created and normed by a white middle-class culture and may have little meaning or relevance for some individuals (Suzuki & Kugler, 1995). Persons raised and educated in the United States are often afraid of taking tests. This can be extremely intimidating, and even overwhelming, for persons from other cultures. Clients with limited fluency in English or limited education may be unable to understand and complete even simple paper and pencil assessments. Having assessments available in the relevant language does not solve all of the problems. In one child abuse agency, some immigrant clients did not understand the concept of responding to a statement using a three-point scale. Others respond in a random manner to cover their lack of understanding of the task, or just to please the person administering the instrument. Thus, special consideration must be given to explaining the purpose of any assessment, assisting in administration of the assessment, and in interpreting the results in culturally sensitive manner.

The ethical guidelines that most mental health professionals adhere to were created in the context of the majority culture and therefore are not always relevant or realistic for those who work in multicultural settings. For example, multiple relationships are not avoidable, particularly in smaller communities in which there is a lack of ethnic or bilingual mental health professionals (LaFromboise, Foster, & James, 1996). Culturally sensitive therapists working to earn the trust of individuals or families may choose to participate in functions outside of therapy. For example, a therapist might attend a graduation or award ceremony as a way to show support and foster a trusting connection. Home visits are another example of the frequent need for therapists to stretch themselves to meet the needs of a clientele with limited access to telephones or transportation. When making home visits, it is important to be informed about the norms of a particular culture. For example, there are often strict rules of hospitality, and the visitor can be interpreted as being rude or insulting if norms are violated. In summary, "role clarity" and the maintenance of firm boundaries are not always possible — or even therapeutically indicated — when working with a multicultural clientele. For a thorough discussion of the limited value of multiple relationship prohibitions, see Ebert (1997). Finally, many therapists are uncomfortable receiving gifts from clients. The culturally sensitive mental health professional must differentiate between what is therapeutic and connecting, and what is adherence to a set of professional dictates that may lack cultural relevance. For example, a grandmother who had faithfully brought her three grandsons to therapy for over a year brought a gift to the director, who almost rejected it in her desire to adhere to strict ethical guidelines. Fortunately, a culturally sensitive therapist informed the director that it would be an insult to reject the gift.

Therapists working with child trauma victims frequently must make child abuse reports. Some families may be distrustful of and unknowledgeable about professional mental health services; therefore, it is critical for the therapist to take the time that is needed to ensure that clients understand the therapist's mandate regarding child abuse. As with any counseling situation, when working in a multicultural context it is essential to begin with a clear and thorough informed consent process. Culturally sensitive therapists are aware that they may encounter manifestations of culturally appropriate healing practices (Keitel, Kopala, & Georgiades, 1995) and take the initiative to become informed before taking action that might alienate an individual or family from necessary mental health services. For example, Asian cultures often employ rubbing with warm objects for healing purposes. These practices may be effective when applied by traditional healers who understand the entire procedure, which can be time-consuming and incorporate other elements such as chants, songs, incense burning, and so on. This holistic approach is often lost with

the more acculturated generations. In one county, a child was burned and the parents reported for physical abuse. When such a report needs to be made, it is important for all investigating parties to be informed of the cultural issues, and for the therapist to report in as clear and sensitive a manner as possible. In the case of the burn injury, it was critical to understand that the intent had been healing, not physical punishment. A culturally sensitive response must include education and support for both parents and the child.

Working with trauma is challenging, and the challenge becomes greater when working with culturally different children and families. In order for mental health professionals to provide effective and appropriate services, they must understand their own cultural contexts as well as those of the clients they serve. The task force recommends that therapists seek self-knowledge and the recognition of their own biases and assumptions regarding the nature of human behavior and change. While being a culturally sensitive professional is personally and professionally demanding, there is much to gain from being open to the rich and diverse cultural influences that continue to shape our communities.

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